

***THE HEALTH SERVICES COST REVIEW
COMMISSION***

FY 2017 BUDGET

***PRESENTATION TO THE BUDGET COMMITTEES OF THE
MARYLAND GENERAL ASSEMBLY***

MOOR0102
Donna Kinzer
Executive Director, HSCRC

Department of Health and Mental Hygiene

HEALTH SERVICES COST REVIEW COMMISSION - FY 2017 BUDGET PRESENTATION

I. OVERVIEW

The Health Services Cost Review Commission (the “HSCRC,” or “Commission”) was established in 1971 with two principal responsibilities: to publicly disclose hospital financial data and to set payment levels for acute care hospital services.¹ Under its authority, The Commission has been able to address the issues of cost containment, access to care, equity in payment, financial stability, and accountability.

Under Maryland’s unique “All-Payer” system, all payers, including Medicare and Medicaid, pay hospitals on the basis of the rates established by the Commission. This “all-payer” nature of the system was originally made possible by the state’s Medicare Waiver that became effective in 1977.

II. THE NEW ALL PAYER MODEL

The State of Maryland is leading a transformative effort to improve care and lower the growth in health care spending. These efforts will benefit consumers, business, government, and other purchasers of care. Stated in terms of the “Three Part Aim,” the goal is a health care system that enhances patient care, improves health, and lowers total costs.

Maryland worked closely with the Centers for Medicare & Medicaid Services (CMS) throughout 2013 to design an innovative plan that would make the State a national leader in achieving the Three Part Aim and permit the federal government to continue to participate in the four-decade long all-payer hospital payment system that has proven to be both successful and enduring. The federal government approved Maryland’s new Model Design application, and implementation began in January 2014.

The Model as approved by CMS includes cost savings and quality improvement requirements including:

- All-Payer total hospital per capita annual revenue growth no greater than 3.58%;
- Medicare payment savings of \$330 million over five years relative to the national growth rate;
- Aggregate Medicare 30-day unadjusted, all-cause, all-site readmission rate reduction to the corresponding national average over five years;
- An annual aggregate reduction of 6.89% in Potentially Preventable Conditions (PPCs) over five years, which will result in a cumulative reduction of 30% in PPCs over the life of the model; and
- Other outcomes and quality indicators to be measured and monitored.

Before the start of the fourth year of the model, Maryland will develop a proposal to extend the model beyond the initial five years to focus on the total cost of care and outcomes across the delivery system that encompasses both hospital and community providers and services.

In the past 25 months, the State, in close partnership with providers, payers, and consumers has made significant progress in this statewide modernization effort. Accomplishments include:

- More than 95% of hospital revenues is now under global budgets, which assures that revenue growth can be maintained within the limits while shifting the focus to improve care delivery and focus on population health, both within hospitals and in the community;
- Key quality payment policy enhancements have been adopted to be consistent with the new Model;

¹ The Commission consists of seven members appointed to four-year terms by the Governor and is staffed by 37 full-time positions. The Commission regulates an industry of 47 acute care hospitals, five private psychiatric hospitals, and three chronic care hospitals, with system revenues in excess of \$16 billion in gross charges.

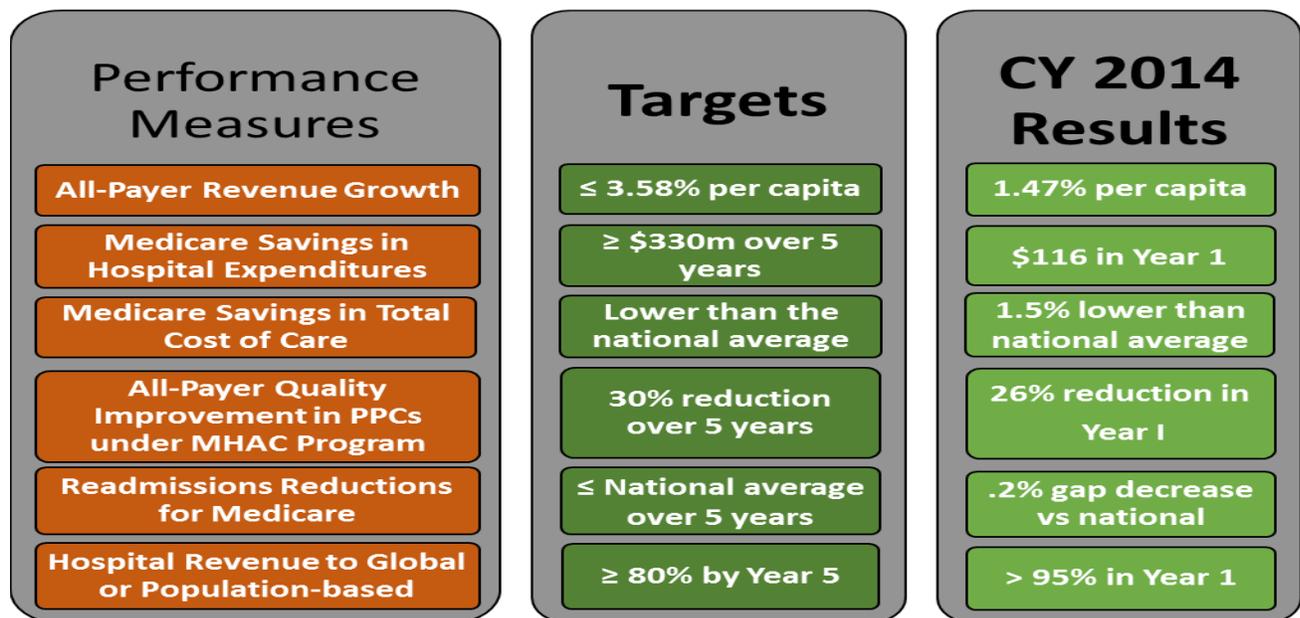
- Overall hospital financial conditions continue to improve;
- Monthly progress monitoring shows performance within the limits of the all-payer requirements;
- Maryland Hospital Acquired Conditions have been reduced beyond the required targets;
- Discussions have ensued with stakeholders and CMS regarding improving provider alignment and progressing the model to be even more population health focused; and
- Over one hundred fifty stakeholders including consumers, physicians, hospitals, other community providers, payers, and business have been engaged in implementation workgroups.

Monitoring Performance

On November 12, 2015, CMS published an article in the *New England Journal of Medicine* outlining the success of the All-Payer Model in meeting the required goals and metrics in the first year of the Model. CMS found that quality at Maryland hospitals improved, while cost growth was constrained compared to historic levels. As a result, those who pay for hospital services in Maryland (such as individuals, business, and insurers) are experiencing reduced hospital cost growth, and Maryland patients are receiving better hospital care with improved outcomes. In addition, hospitals in the State are now more inclined to assist patients after they leave the hospital to get the care and services that they need outside of the hospital so they will not have to return for care. These types of results are mutually beneficial for both patients and hospitals.

Figure 1 below illustrates how Maryland performed on the All-Payer Model metrics in year one. As a result of the incentives in place under global budgets, even as the Model demonstrated success in reducing unnecessary utilization and improving on quality measures, hospital operating profits have continued to increase.

Figure 1. Maryland Model Performance Year 1.



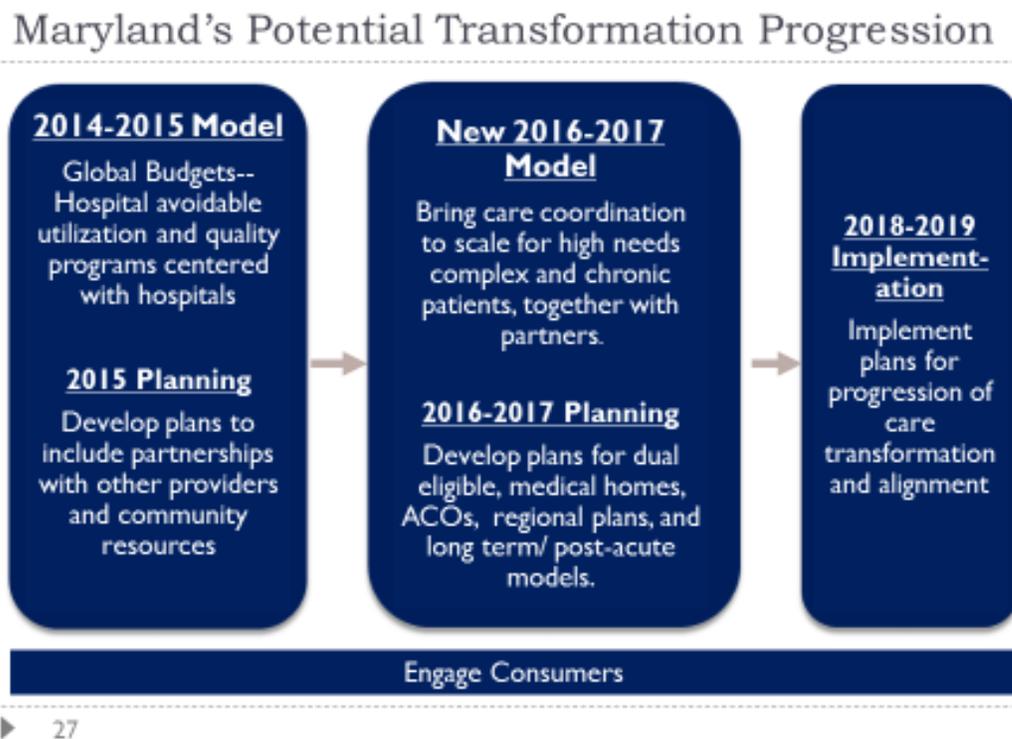
The Commission has been continuing to monitor performance into year two (CY 2015) and is finding that through November, overall hospital volume growth and per-capita revenue growth continue to be limited

consistent with the provisions of the Model. Also, there continues to be improvement in quality and readmission measures. In order to meet the five-year readmission goal however, further improvement needs to be made. Therefore, particular focus has been and will continue to be placed on reducing Medicare readmissions. In addition, data show that Medicare hospital growth is above HSCRC targets and that while Medicare utilization per beneficiary is declining, there is a need for substantial progress beyond current levels of reduction. The Commission has also noted excess growth in Medicare costs outside of hospitals through July 2015.

Implementation and Stakeholder Engagement

As the State’s rate setting authority, HSCRC is playing a vital role in the implementation of this innovative approach to health care transformation. The HSCRC with guidance from its All-Payer Modernization Advisory Council and various stakeholder involved work groups has been working under a comprehensive transformation progression plan. An outline of this plan is illustrated in Figure 2.

Figure 2: All-Payer Model Transformation Plan



In the development and implementation of this plan, the HSCRC has emphasized broad public engagement by convening the Advisory Council and a series of work groups to provide guidance on the design and implementation of the new system. Below is a listing of those groups.

- **The Advisory Council** provided broad input on the guiding principles for the HSCRC and DHMH to consider in implementation of the new payment and delivery systems design.

- **ICN-Care Coordination Work Group** made recommendations on establishing an infrastructure that can support care coordination and alignment activities among hospitals, community providers, community organizations, and consumers.
- **Two Consumer Task Forces, Consumer Engagement and Consumer Outreach**, both made a series of recommendations to help educate consumers and patients; enable better input from consumers in their care and on the development of a transformed delivery system; provide messaging to consumers on what the All-Payer Model means to them; and move forward on the implementation of a faith-based initiative.
- **The Physician Alignment and Engagement Work Group** made recommendations for aligning care coordination and improvement activities and for opportunities to improve financial alignment with physicians and other health care providers to achieve the goals of the Model.
- **The Payment Models Workgroup** developed recommendations for the HSCRC on the structure of payment models and how to balance its approach to updates.
- **The Performance Improvement and Measurement Work Group** developed recommendations on measures that are reliable, informative, and practical for assessing issues such as reducing Potentially Avoidable Utilization (PAU), value-based payment, patient experience of care, and patient-centered outcomes.
- **The Data and Infrastructure Work Group** developed recommendations to the HSCRC on the data and infrastructure requirements needed to support oversight and monitoring of the new hospital All-Payer Model and achieve successful performance.

The Advisory Council, which has resumed meeting, has been expanded to include additional physicians, nursing homes, and other members. The Commission is also establishing a new work group on Alignment Infrastructure which includes subgroups on care delivery for the dual eligible population, primary care, further developments to the global budget model, and establishing support for care integration referred to as integrated care networks or ICN.

A description of the activities of the Advisory Council and Work Groups (as well as those of the Commission) can be found on the Commission's website. All Commission, Advisory Council, and Work group meetings are open to the public and provide opportunity for public comment. Consumer/patient representatives have been included on all Work Groups.

What is next for the All-Payer Model

In order to achieve sustainable improvements in care delivery that can result in decreases in avoidable hospitalizations, care delivery needs to be transformed. In particular:

- Complex and high needs patients need to have enhanced care coordination;
- Hospitals need to work with long-term and post-acute care providers to improve care in ways that will prevent avoidable hospitalizations and re-hospitalizations; and
- Hospitals need to work with primary care, behavioral health, and other community based providers and community organizations caring for complex high need patients and patients with multiple chronic conditions in order to coordinate care, improve health, and prevent avoidable hospitalizations.

As previously indicated, HSCRC convened a multi-agency Work Group, the ICN-Care Coordination Work Group, to focus on how to implement care coordination in Maryland. In its May 2015 report, the ICN-Care Coordination Workgroup laid out a person-centered approach to transforming the delivery of health care, tailoring care to persons' needs and increasing the focus on complex, high needs individuals and those with chronic conditions. This requires an intense level of intervention for an estimated 25,000 to 40,000 individuals who are not already being supported by payers and who need community-based care management or other intense interventions on an extended basis. Many of the commercial carriers and Medicaid Managed Care Organizations in Maryland offer care management and also medical homes/primary care focus that extends to patients with higher needs and chronic conditions.

The efforts undertaken by some health plans are designed to increase care and support provided in the community with the result of better health and avoided hospitalizations. However, Medicare patients in Maryland have few of these supports available, despite their greater need. In order to implement a similar approach for Medicare patients, we estimated the need for chronic care management for an additional 200,000+ Medicare and dually eligible (eligible for both Medicare and Medicaid) beneficiaries who are primarily in fee-for-service, Medicare programs. Bringing care coordination to scale is a large and complex undertaking because it requires the ability to communicate effectively among many parties where limited communication has existed in the past, and to execute care management with a large number of individuals.

It will be difficult to execute care coordination successfully on a "one-off" basis with each hospital developing its own tools, because successful care coordination necessarily involves the community, comprised of thousands of primary care providers, specialists, case managers, and patients. The ICN-Care Coordination workgroup recommended standardization of certain elements and tools, but left open the approach with the expectation that regional partnerships would tackle some of the issues regarding scaling and standardization at the community level.

Under global budgets, the Commission has included additional dollars in the rates of all hospitals to provide for investments for patients with the goals of improving care and improving health while also reducing avoidable utilization. The purpose of these monies is to accelerate the development of care coordination and other interventions relative to these goals, which we refer to as infrastructure investments. Below are three sets of reports that have been submitted from hospitals to the Commission over the past few months. These reports may be found on the Commission's website at: <http://www.hscrc.maryland.gov/plans.cfm>

- **Global Budget Infrastructure Investment Reports:** The first report summarizes hospital reported expenditures relative to infrastructure. The Commission required that all hospitals report on their investments for fiscal years 2014 and 2015.
- **Regional Partnership Reports:** The second report summarizes the eight regional partnership reports on plans and activities. The Regional Partnerships are a critical part of the State's approach to target high need/high-resource patients in order to improve outcomes, lower costs, and enhance patient experience. The purpose of the Regional Partnerships is to foster collaboration among hospitals together with community-based partners to target services based on patient and population needs, collaborate on analytics, and plan and develop care coordination, chronic care management, and other approaches that reduce avoidable hospitalizations.
- **Strategic Hospital Transformation Plans:** The third report summarizes the Strategic Hospital Transformation Plans or "STPs". During the June 2015 public meeting, the Commission approved a recommendation that required all acute care hospitals in the State to submit a plan to the Commission summarizing their short-term and long-term strategies and incremental investment plans for

improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with non-hospital providers.

The All-Payer Model allows Maryland to adopt new and innovative policies aimed at improving care, improving population health, and moderating the growth in hospital costs. Transforming Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities requires increased collaboration among health systems, payers, community hospitals, ambulatory physician practices, long-term care, and other providers, as well as patients, and public health and community-based organizations. Furthering progress is dependent on advancing care redesign, alignment and supporting infrastructure. To that end, the Commission, DHMH, and other agencies are coordinating efforts focused on the following activities:

- Improving health information exchange at the point of care– focus on connecting physicians, long term care facilities, and other providers and creating tools at CRISP for greater connectivity;
- Engaging providers in regional planning and implementation of care coordination;
- Negotiating approvals with CMS needed to facilitate financial and clinical relationships between hospitals and other providers;
- Developing plans for additional financial alignment and care delivery integration models focused on high needs patients together with stakeholders around the State;
- Developing plans for a dual eligible (people enrolled in both Medicare and Medicaid) Accountable Care Organization (ACO) for implementation in 2019; and
- Beginning preparation of a plan, together with stakeholders, for progression and extension of the Maryland All-Payer Model, incorporating plans to focus on limiting the growth in total cost of care for Medicare patients (due at end of 2016).

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DLS ISSUES

1. HSCRC should comment on the status of the internal physician and P4O waivers, and what progress has been made on the movement toward Phase II of the All-payer Model Contract, including possibly more aggressive outreach to the nonhospital provider community.

The Physician Alignment Work group recommended that the Commission pursue non-compensatory and compensatory strategies toward physician alignment. Those strategies include:

- Non-compensatory:
 - Shared infrastructure, analytics, and other resources;
 - Better health care quality and reporting; and
 - Investment to improve care management support.

- Compensatory:
 - Pay for Performance (or Outcomes);
 - Gain Sharing;
 - Shared Savings; and
 - A continuum of case-based, episode-based, and population-based models.

Following these recommendations, the Commission has continued informal and formal conversations with key stakeholders on principles and elements of successful alignment models. Since Maryland is currently under a per capita hospital model, stakeholders agree that Maryland should endeavor to obtain approvals for alignment activities that are available to Accountable Care Organizations throughout the nation. In order to continue success, make progress and create sustainability of the model, the Maryland delivery system needs to engage in transformation activities with other providers, communities, and patients: 1) care coordination to address the needs of complex patients in the community setting; 2) enhanced chronic care management to reduce the impact of these conditions on patients, and 3) population health improvement, with the expected result of reducing avoidable hospital utilization. Hospitals also need to work with their hospital-based providers to offer more efficient services, with an increasing focus on effectively managing acute care events beyond the hospital stay. The purpose of these approvals is to allow incentive payments and investments in resources focused on care improvements that will also reduce avoidable hospital utilization and internal hospital costs.

In response to stakeholder input and the needs for model progression, HSCRC and DHMH representatives have been coordinating discussions to incorporate approvals for financial incentive programs for providers, shared care coordination resources, and Medicare data to support care coordination and care redesign efforts into the All Payer Model Agreement with CMS. Additional stakeholder input and review and approvals by CMS will be required before Amendments can move forward. The discussions currently contemplate:

- An internal cost sharing model (gain sharing) - This model would permit hospitals to share savings with hospital-based physicians and physicians with admitting privileges when quality is improved and care is coordinated with other providers.

- Pay for Outcomes – This model would permit hospitals to partner with non-hospital providers such as primary care physicians and post-acute care providers to share resources (data, analytics,

and personnel) and to share savings when better community based care results in a reduction in avoidable hospitalizations.

- Sharing Medicare Data on Total Cost of Care – This would permit Maryland providers to obtain data similar to the data that is provided to Accountable Care Organizations. This data could be used to improve care coordination by allowing for risk stratification to identify complex and high needs patients who could benefit from increased system supports. It could also be utilized to identify system opportunities and to understand trends in total cost of care growth within geographic areas of the State.

As these discussions are occurring with CMMI, the Commission will also be taking advice from a broad set of stakeholders through an Advisory Council and a new Alignment Infrastructure Work Group on how such programs can be practically implemented. The Commission is hopeful to have a determination or at least a strong indication of the status of obtaining these waivers by the beginning of Fiscal Year 2017.

2. HSCRC should comment on the current status of the Integrated Care Network (ICN) projects, where the infrastructure build-out is so far, and what steps they plan to take to get more small, nonhospital-based providers into the ICNs.

Throughout FY15, CRISP worked with HSCRC and various stakeholders on alignment and ICN planning. Since the beginning of FY16, MHCC and HSCRC have engaged CRISP to build out a technical infrastructure for an integrated care network (ICN) to support coordinated care throughout the State in a manner that aligns with the All-Payer Model. In the first seven months, CRISP has built out the team to deliver the seven work-streams of activity related to the ICN infrastructure. As of February 1, the **Ambulatory Connectivity** work-stream has connected to 1584 physicians (representing 229 practice sites) with “Tier 2” connectivity (encounter data from administrative and clearinghouse data sources), and 14 physicians (six practice sites) with “Tier 3” connectivity (clinical data from Consolidated Clinical Document Architecture or C-CDA data). CRISP’s current pipeline has an additional 2696 physicians, which represents an even greater total number of providers. While the majority of this first wave of ambulatory providers connecting to CRISP originate from larger groups or hospital-affiliated practices, CRISP is aggressively focusing its efforts on small provider practices—especially through collective arrangements with cloud-based electronic health records (EHRs). With more than 300 different EHR systems in the ambulatory market in Maryland, many of them standalone systems, the integration of small practices is a labor-intensive effort. CRISP’s ability to convince small practices to connect will be significantly enhanced when the State’s physician alignment strategy is announced.

CRISP is working in partnership with HSCRC and other stakeholders such as MedChi to communicate financial alignment strategies that will give small providers more incentive to participate in and benefit from the care coordination tools becoming available through CRISP.

CRISP has made progress on its **Data Router** work-stream to support more granular patient consent options. Version 1.0 is on track for completion in March 2016. The **Clinical Portal Enhancements** work-stream has successfully released a new Care Profile tab in the CRISP Clinical Query Portal. The Care Profile tab currently includes a list of providers subscribed to encounter notifications and any available care plans. Additional modules will be added to the Care Profile throughout the year. The **Alerts and Notifications** work-stream has completed an RFP process for a secure texting solution and will begin pilots within the next 30 days. The team is working on a notification of care plan availability and is piloting cross-hospital delivery of Care Alerts (short messages written by clinicians that highlight critical clinical information on an individual patient should they be admitted elsewhere).

The **Reporting and Analytics** work-stream has released the much-anticipated Patient Total Hospitalization (PaTH) report based on case mix data and is training and credentialing new users of the report. The team has tested a number of risk stratification methodologies and will be adding hierarchical condition categories (HCC) risk scores to reports. Other scoring methods may be employed as new data sources are added, which enhance the value of more dynamic risk stratification models. The CRISP team is working with the State and CMMI to obtain Medicare data to improve patient care through care coordination support. The **Basic Care Management Software** work-stream has launched three separate pilots to evaluate the two different approaches to supporting care management. One approach is a shared care management software platform (piloting Mirth Care) that can be scaled to support multiple instances of care managers and is connected directly to CRISP technology stack. The second approach is to develop Application Program Interfaces (APIs) to connect with multiple care management software systems (pilot testing Caradigm and eQHealth). The **Practice Transformation** work-stream has been focusing on educating practices on CRISP's core services, namely the Encounter Notification Service (ENS) and the Query Portal enhancements. This work-stream will shift its focus significantly once the physician alignment strategy is announced.

In addition to the seven work-streams, CRISP has developed a new **Customer Success Program** to help key CRISP participants (initially focused on the Regional Partnerships as well as Maryland's acute care hospitals) to help them optimize the use of CRISP's tools and services, which are growing in number, scope and complexity. CRISP has signed five memoranda of understanding with the funded Regional Partnerships and plans to complete at least a dozen Customer Success Plans with Maryland hospitals by June.

3. Both commissions should comment on their progress toward addressing the DLS recommendations, including the ability of each commission to function under the current user fee assessment caps.

Although each Commission has its own distinct form and function in the regulation and oversight of the health care delivery and financing structure in Maryland, the HSCRC and MHCC have worked very closely together where those functions dovetail. In recent years, the HSCRC has also been collaborating with the Maryland Community Health Resources Commission (MCHRC) since a strong community provider system is important to success on the All-Payer Model. Examples of continued collaboration include:

- Support and oversight of CRISP;
- Use and support of the All-Payer Claim Data Base;
- Shared data for quality reporting and other utilization reporting;
- Involvement in each Commission's grant processes;
- Participation and support of Consumer Task forces;
- Addressing aspects of the Certificate of Need applications and changes in hospital services; and
- Implementation of the Trauma Fund.

The cooperation and separate expertise of the health regulatory Commissions have contributed to the success of Maryland's thriving and successful health care industry that has been widely recognized nationally over the years. We look forward to continuing to be a partner with these Commissions and the Department of Health and Mental Hygiene as we progress toward the State's overall goals of improving population health.

Over the past three years, the Commission has been able to meet All-Payer Model implementation needs

by utilizing expert contractors, technical assistance, analytics enhancements, and educating staff. As a result, the Commission's contract budget has grown and the FY 2017 budget will bring the Commission's user fee assessment close to the \$12 million cap. As the State assesses the progression and extension of the model it is essential for the Commission to evaluate its support contracts, staffing configuration and expertise. We also need to evaluate the opportunity to develop the ICN concept, which focuses on enhancement of public/private resources to optimize infrastructure that can assist with implementation needs and also support provider alignment. However, we need to complete the planning process and discussions with CMS and stakeholders regarding the progression of the Model before we can finalize plans for the HSCRC.

The 2015 BRFA required that MHIP surplus dollars that were generated from public payers shall be used over the next three to four years to support the process of developing integrated care networks and infrastructure geared toward Medicare and dual eligible beneficiaries, consistent with the goals of the All-Payer Model. As indicated in the analysis, much of the planning work is currently being conducted by CRISP. These ICN dollars will help the Commission obtain the needed technical assistance, and implement the necessary ICN alignment models for the next three years or so. The HSCRC and MHCC will continue to monitor the efficacy of implementation of the ICN, and as the necessary waivers are granted and the Model is broadened by CMMI, we will adjust to ensure that the All-Payer Model is meeting the needs of patients and providers in Maryland.



CHANGING
Maryland
for the Better

COMMUNITY HEALTH RESOURCES COMMISSION

Mark Luckner, Executive Director
Community Health Resources Commission

Presented to:

House Appropriations Health & Human Resources Subcommittee

February 11, 2016



BACKGROUND ON THE CHRC

- **The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access for low-income Marylanders and underserved communities.**
- **Statutory responsibilities include:**
 - Increase access to primary and specialty care through community health resources
 - Promote community-hospital partnerships and emergency department diversion programs to prevent avoidable hospital utilization
 - Facilitate the adoption of health information technology
 - Promote long-term sustainability of community health resources as Maryland implements health care reform



BACKGROUND ON THE CHRC

- **The CHRC is an independent agency operating within the Maryland Department of Health and Mental Hygiene.**
- **Eleven Commissioners of the CHRC are appointed by the Governor (one current vacancy).**

John A. Hurson, Chairman

Nelson Sabatini, Vice Chairman

Elizabeth Chung, Executive Director,
Asian American Center of Frederick

Charlene Dukes, President, Prince
George's County Community College

Maritha R. Gay, Executive Director of
Community Benefit and External Affairs,
Kaiser Foundation Health Plan of the
Mid-Atlantic States Region

William Jaquis, M.D., Chief,
Department of Emergency Medicine,
Sinai Hospital

Sue Kullen, Southern Maryland Field
Representative, U.S. Senator Ben
Cardin

Paula McLellan, CEO, Family Health
Centers of Baltimore

Barry Ronan, President and CEO,
Western Maryland Health System

Maria Harris Tildon, Senior Vice
President for Public Policy & Community
Affairs, CareFirst BlueCross BlueShield



BACKGROUND ON THE CHRC

The CHRC grants have focused on the following public health priorities:



Reducing infant mortality



Integrating behavioral health



Promoting ED diversion programs



Investing in health information technology



Expanding primary care access



Addressing childhood obesity



Increasing access to dental care



Building safety net capacity



IMPACT OF CHRC GRANTS

- Since 2007, CHRC has awarded 154 grants totaling \$52.3 million. Most grants are awarded for multiple program years.
- CHRC has supported programs in all 24 jurisdictions.
- These programs have collectively served approximately 260,000 Marylanders.
- Most grants are awarded to community based safety net providers, including federally qualified health centers (FQHCs), local health departments, free clinics, and outpatient behavioral health providers.



SUPPORTING SUSTAINABILITY

- Encourage programs to be sustainable after initial “seed” grant funding is expended.
- Utilize CHRC grant funding to leverage additional federal and private/non-profit funding.

\$52.3M awarded to grantees

\$18.8M in additional resources

\$14.9M in private, nonprofit, or local resources

\$3.8M in federal resources

Weinberg Foundation
 \$250,000 to West Cecil
 Community Health Center

CareFirst
 \$447,612 to Access to
 Wholistic. & Prod. Living

HRSA New Access Point
 \$425,874 to Mobile Med



Chapter 328 in 2014 re-authorized the CHRC until 2025. This vote was unanimous.

- **Demonstrated track record in distributing and managing public funds efficiently**
 - 41 grants, totaling \$13.4 million, under implementation
- **Grantee accountability (both fiscal and programmatic)**
- **CHRC overhead is 7% of its \$8 million budget**
 - Monitored by CHRC staff of four PINs
- **Pilot innovative ideas that are later replicated statewide**
 - **Way Station** – Medicaid Behavioral Health Home Pilot
 - **Allegany Health Right/WMHS Dental Partnership**



CHRC GRANT MONITORING

- **CHRC grants are monitored closely.**
- **Twice a year, as condition of payment of funds, grantees submit program narratives, performance metrics, and an expenditure report.**
- **Grantee progress reports (sample above) are a collection of process and outcome (some) metrics; grantees are held accountable for performance.**

CHRC Grantee Monitoring Report		SHIP Focus Area(s) & Measure(s):		
Grantee:	Harford County Health Department	Healthy Beginnings - Early prenatal care; Infant death rate; Babies with low birth weight; Sudden unexpected infant death rate		
Grant #:	15-008	Quality Preventative Care - ED visits due to diabetes; ED visits due to Hypertension		
Reporting Period:	Report #1: May 1, 2015 - October 31, 2015			
Project Goal(s):	Improve health outcomes and reduce costs through community-based, comprehensive care coordination of high risk, high-cost populations.			
NOTE #1: Any measurement counting "unduplicated" patients CANNOT include the same patients over different reporting periods. The "Totals" column for these measures should sum only unique individuals. For example, if an individual is counted in reporting period 1, then that person should <u>not</u> be counted again in reporting period 2.				
NOTE #2: The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.				
NOTE #3: The CHRC will utilize output 1f for its " Total Patients/clients Engaged " measure, and output 1g and 1h for its " Total Patient/client encounters " measures.				
NOTE #4: "Patient/Client Encounters" is defined as any face-to-face or telephonic contact with a nurse care manager in a care coordination program.				
Process Metrics				
Key Project Objectives	Output	Data Source	Year One	
			Reporting Period #1	Reporting Period #2
Improve health outcomes for low income patients through Nurse Case Management	1a) # of clients referred to Nurse Case Manager from UM-UCH Emergency Department	Internal Data Tracking System		
	1b) # of clients referred to Nurse Case Manager from Beacon Health	Internal Data Tracking System		
	1c) # of clients referred to Nurse Case Manager from UM-UCH Birthing Unit	Internal Data Tracking System		
	1d) # of clients referred to Nurse Case Manager from other Community Medical Providers	Internal Data Tracking System		
	1e) Total # of unduplicated clients referred to Nurse Case Manager	Internal Data Tracking System		
	1f) Total # of referred clients successfully engaged with Nurse Case Manager*	Internal Data Tracking System		
	1g) Total # of patient encounters, face-to-face, by Nurse Case Manager	Internal Data Tracking System		



CONTINUED IMPORTANCE OF COMMUNITY HEALTH RESOURCES

- **Health insurance does not always mean access.**
 - FQHCs and other community health resources may be the best option for newly insured because many non-safety net providers do not accept new patients or have long wait times
- **Historical mission of serving low-income individuals who are impacted by social determinants and have special health and social service needs.**
 - Health literacy - critical role of safety net providers
- **Demand for health services by the newly insured dramatically outpaces the supply of providers.**
 - 81% of FQHCs nationally have seen an increase in patients in the last 3 years



- **Assist ongoing health care reform efforts.**
 - Build capacity of safety net providers to serve newly insured
 - Assist safety net providers in IT, data collection, business planning
 - Promote long-term financial sustainability of providers of last resort
- **Support All-Payer Hospital Model and health system transformation.**
 - Provide initial seed funding for community-hospital partnerships
 - Fund community-based intervention strategies that help achieve reductions in avoidable hospital utilization
 - Issued white paper, “Sustaining Community-Hospital Partnerships to Improve Population Health” (authored by Frances B. Phillips)
- **Support population health improvement activities.**
 - Align with State Health Improvement Process (SHIP) goals
 - Build infrastructure of Local Health Improvement Coalitions



EXAMPLES OF CHRC GRANTS



*lower
shore
clinic*

Three-year grant to free clinic enabled grantee to implement financially sustainable dental program, serving 750 patients to date and generating \$40,000 in program revenue.

Two-year grant enabled behavioral health clinic to add primary care services. Increased revenues from \$1.3M to \$4.4M. Also leveraged CHRC funding to attract \$600,000 in federal funds.



Three-year ED diversion/care coordination grant targeted high utilizers, resulting in an 80% reduction in inpatient stays and 67% reduction in ED visits (4 months pre vs. post-intervention) which translates into savings/avoided charges of \$632,492.



Three-year grant to free clinic enabled organization to lay the ground work to transition to FQHC status and receive a \$900,000 NAP award.



FY 2016 CALL FOR PROPOSALS



STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336
Office (410) 260-6290 Fax No. (410) 626-0304

Larry Hogan, Governor – Boyd Rutherford, Lt. Governor
John A. Hurson, Chairman – Mark Luckner, Executive Director

Supporting Community Health Resources:
Building Capacity, Expanding Access,
Promoting Health Equity, and Improving Population Health

Call for Proposals

November 10, 2015

Key Dates:

November 10, 2015 – Release of
Call for Proposals

January 11, 2016 – Applications due
January/February – Grant Review
Period

Mid-March – Presentations and
Award Decisions

Three strategic priorities:

- (1) Expand capacity;
- (2) Reduce health disparities; and
- (3) Support efforts to reduce avoidable hospital utilization.



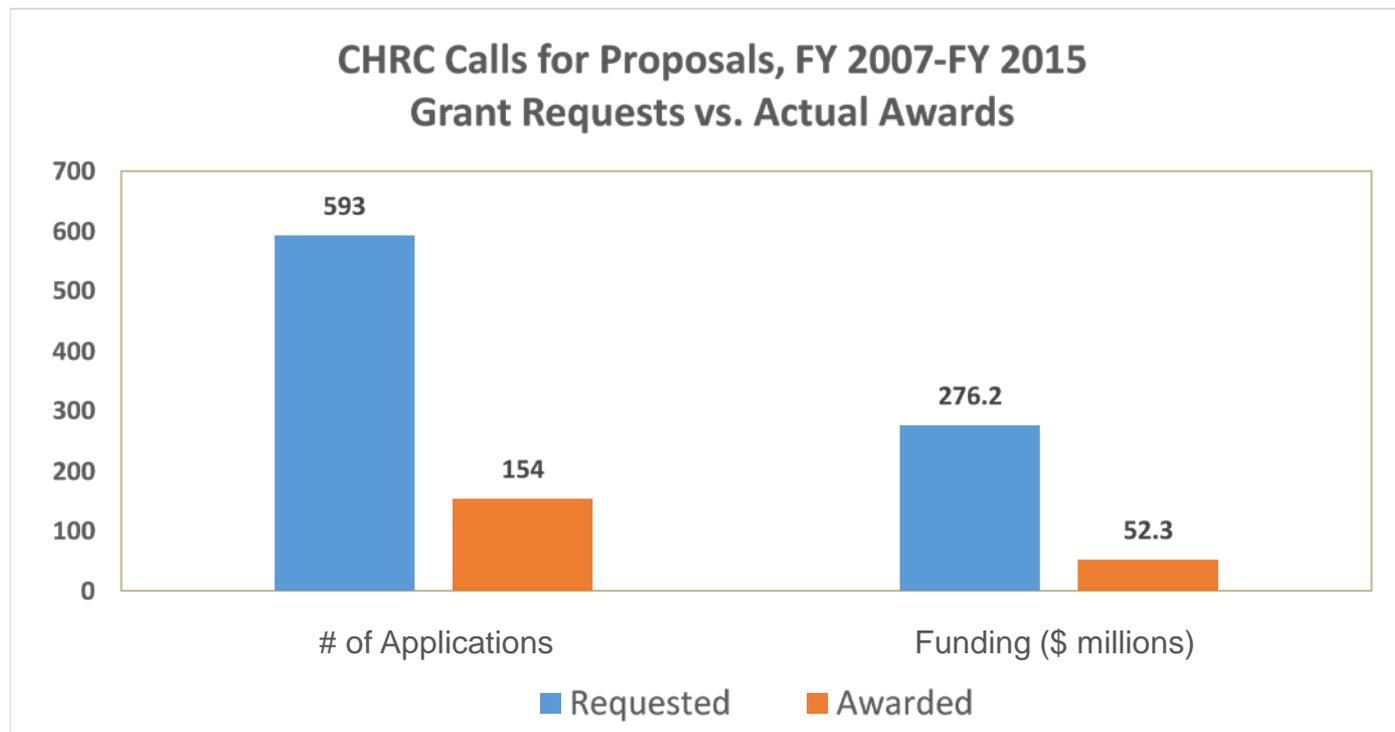
FY 2016 CALL FOR PROPOSALS

- **Generated 71 proposals totaling \$17 million in year-one funding (FY 2016 budget - \$1 million is available).**
- **Most proposals seek funding for multiple years. Total requested in RFP was \$31.6 million.**
- **RFP includes 4 types of projects:**
 1. **Women's health/infant mortality** - 4 proposals, \$1.7M
 2. **Dental care** - 12 proposals, \$2.8M
 3. **Behavioral health/heroin and opioid epidemic** - 20 proposals, \$9.8M
 4. **Primary care and chronic disease management** - 35 proposals, \$17.5M



CHRC BUDGET AND GRANT REQUESTS

- Demand for grant funding exceeds CHRC's budget.
- The Commission has funded approximately 19% of requests.



THE MARYLAND HEALTH CARE COMMISSION

FY 2017 BUDGET

PRESENTATION TO THE LEGISLATURE

**M00R0101
Ben Steffen
Executive Director**

Department of Health and Mental Hygiene

DLS ISSUES

1. Both commissions should comment on their progress toward addressing the DLS recommendations, including the ability of each commission to function under the current user fee assessment caps.

The MHCC and HSCRC have a long-established record of collaborating on health care functions. At the same time in certain areas particularly in the area of facility planning the Commissions operate more independently. In the past four years, the two Commissions have broadened and strengthened collaborative relationships. These collaborations do not represent duplications of effort, but rather conscious, deliberate divisions of duties based on assessments of which Commission is best to positioned statutorily and fiscally to undertake the work. In some instances, these relationships have been formalized through memorandums of understanding (MOUs).

Key collaborations of particular emphasis include:

Diffusion of Health Information Technology: MHCC is responsible for designating and monitoring the state-designated health information exchange. HSCRC through its hospital rate setting authority can provide funding for this important information resource. Today, the Commissions are working together to unleash the full potential of health information exchange to support both clinical care and the new global payment model.

Aligning Cost and Quality Information Systems and Reporting: The MHCC and HSCRC each have key data collection efforts. MHCC focus is on the collection and reporting of health care spending and performance information. Consistent with its oversight of hospital rates, HSCRC focus is on hospital utilization and spending. Both commissions are heavy users of the other organization's data systems. MHCC makes extensive use of HSCRC hospital data in our quality reporting and health planning activities. HSCRC makes extensive use of MHCC hospital quality measures for the HSCRC's Quality Based Reimbursement efforts. In the future, even greater collaborations are planned as we jointly use our shared data systems to drive improvements in quality and reductions in costs.

Health Delivery System Reform: The commissions are working collaborative, with DHMH, and consumers to develop new approaches that align with the overarching goals of improving the patient experience of care, improving the health of populations, and lowering the capita per cost of health care. Each commission as well DHMH, stakeholders, and consumers have important roles. A priority for the MHCC is to continue to engage primary care providers in the new delivery models even as HSCRC asks health systems to be more accountable.

Administrative Alignment and Coordination: Both commissions pride themselves on efficient and nimble administrative framework. Management at both organizations is limited and serve the roles of both technical leaders and managers. Over the last several years, the commissions have worked together to generate even greater efficiencies. The Chairs of the respective commissions work together and send clear messages to commissioners and staff alike that collaboration is a core organization value. At the operational level, executive directors and center directors work together to plan and implement common strategies for diffusing information technology and developing new cost and quality

information systems. Administrative units work together seamless in monitoring shared initiatives, developing and managing MOUs and other agreements, and in designing and reviewing RFPs

An assessment on payers, hospitals, health care professionals, and nursing homes funds operations of the MHCC. The \$12 million assessment cap was established in 2008, although the MHCC responsibilities have expanded significantly since. The past two administrations have asked MHCC to operate within the existing spending cap. MHCC has met this directive by restraining spending, aggressively competing for federal and other grants that can augment state funds, and by developing charge-back agreements with other agencies to whom we provide services or information. MHCC closed FY 2015 with a \$3 million surplus and we project that FY 2016 will close with a surplus of roughly \$2.7 million. The surplus and the projected assessment of \$12 million will be sufficient to fund the FY 2017 budget.

In parallel with the funding cap, MHCC is also considering new approaches to equitably distributing the assessment among the four health care categories. MHCC currently establishes the relative shares based on a retrospective workload study conducted every four years. Implicit in this approach is an assumption the past workload is a reasonable predictor of the future workload. An approach that accounts for experience and future obligations may be a more equitable basis for equitably distributing the assessment. This approach has been broadly endorsed by DLS in its recommendations to the Legislature. Staff will present an approach for implementing the new scheme to the Commissioner this spring.